SOCIAL WORK ASSESSMENT

Name of Applicant: _____ **Gender**: ( ) M ( ) F
Date: _____ **SS #:** _____

Military History:
Dates Served: _____ **Branch**: _____
POW: ( ) No ( ) Yes If Yes, When and Where: _____
_____
Marital Status: ( ) S ( ) M ( ) D ( ) W
Level of Education: _____
Employment History: Date Last Worked_____
Type of Work Performed: _____
_____
Financial History (provide specific amounts)

VA Non-Service Connected Pension:	$_____
VA Service Connected Compensation:	$ _____
SSI	$_____
Social Security Income:	$_____
Retirement / Pension:	$_____
Other Income:	$_____
Total Monthly Income:	**$_____**

Health Insurance:
Medicare ID: _____ Effective Date: _____
Medi-Cal ID: _____ Effective Date: _____
Name of Insurance Co.:_____Plan #: _____
Name of Insurance Co: _____ Plan #: _____
Name of Insurance Co: _____ Plan #: _____

Name and Address of Person Responsible for Funds:
Self: ____ Other: ____ Relation to Applicant: _____
Name: _____
Address: _____
Does this Person Have: _____Financial Power of Attorney
_____Social Security Representative Payee
_____Court Appointed Conservatorship
Mailing Address of Social Security / Pension Check:
_____
Does Applicant Have Advanced Directive: ( ) N ( ) Yes If yes :
Name of Designated Decision- Maker: _____
Address of Designated Person: _____
Phone #: ( ) _____ ( ) _____
Specific Treatment Preferences Noted: _____
_____

History of Substance Abuse / Chemical Dependency (Note Any Current Usage):
_____
_____

Living Arrangements:
With Whom Does the Applicant Live? _____
_____

Ability of That Person to Give Care and /or Limitations Experienced by Caregiver:
_____
_____
_____

Other Relatives / Friends / Caregivers Who Assist with Care, be specific:
_____
_____
_____

Previous Community Agencies Involved In Providing Services: ____MOW
____IHSS ____Private Caregiver _____Other, be specific _____
_____

Does Caregiver Need Respite? ( ) Yes ( ) No
Who Cooks, Cleans and Shops for the Applicant? _____
_____

Who Manages Applicant's Medications? _____
Does the Applicant Need Assistance With Any of the Following ADL's ,be specific:
____Dressing: _____
____Bathing: _____
____Ambulation: _____
How Well Does the Applicant Ambulate? _____
____Use of Assistive Devises: _____
____Toileting: _____
____Transferring (getting out of a chair or bed) _____
____Meals (eating or preparing food) _____
____Special Diet or Texture of Diet: _____
Other: _____
Primary Mode of Transportation: _____
Does the Applicant Have a History of Wandering? ( ) No ( ) Yes If yes, be specific: _____
_____
_____

Does the Applicant Require Supervision for Safety? ( ) No ( ) Yes If yes, be specific: _____
_____
_____

Pattern of Activities in the Home (Daily Routines, Type of Exercise…), be specific:
_____
_____
_____

Applicant's Leisure Activities, be specific:
_____
_____
_____
_____

Applicant / Family's Response to Applicant's Illness, be specific: _____
_____
_____

Why Are Adult Daycare Services Requested? What are the Specific Goals of the Family / Applicant? Be specific:
____Maintain the best quality of life as possible
____Provide socialization
____Social services
____Individual Counseling
____Group therapy
____Personal care services
____Health and social skills
____Enhance self-esteem
____Cognitive and social skills
____Help maintain and improve current level of functioning
____Physical and Occupational therapy
____Other: _____

Services Needed:
Number of Visits per Week: _____
Bath Services: ( ) No ( ) Yes **Number of Times per Week**: _____
Extended Day: ( ) No ( ) Yes **Number of Days per Week**: _____

Provide Other Pertinent Information About the Applicant That May Affect His / Her Participation in ADC / ADHC Services or Further Justify Need For Services:
_____
_____
_____
_____
_____
_____

Completed By: _____ **Date**: _____

Please fax the completed form to Karen Borczon at 818-895-5813. Please fill out all sections completely.